Information Exchange
Provider Directory Task Force
Draft Transcript
January 4, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody, and welcome to the Provider Directory Task Force, which is a task force of the Information Exchange Workgroup. This is a Federal Advisory Committee, so there will be an opportunity at the end of the call for the public to make comments. The call will run from 10:00 to noon eastern time.

Let me do a quick roll call. Peter DeVault from Epic?

Peter DeVault – Epic Systems – Project Manager
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Paul Egerman?

Paul Egerman – Software Entrepreneur
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Seth Foldy? Jonah Frohlich?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Jim Golden?

Jim Golden – Minnesota Department of Health
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Dave Goetz? Hunt Blair?

Hunt Blair – OVHA – Deputy Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Steve Stack?

Steve Stack – St. Joseph Hospital East – Chair, ER Dept
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Walter Suarez is not joining today. Art Davidson? George Oestrich? Sorin Davis?

Sorin Davis – CAQH – Managing Director, Universal Provider Data Source (UPD)
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Keith Hess? Sid Thorton?

Sid Thorton – Intermountain – Senior Medical Informaticist
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Lisa Robins? JP Little? Mickey Tripathi?

Mickey Tripathi – Massachusetts eHealth Collaborative – President & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Kory Mertz?

Kory Mertz – NCSL – Policy Associate
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Tim Andrews? Did I leave anyone off?

Dave Goetz – State of Tennessee – Commissioner, Finance Department & Administration
Dave Goetz.

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning. I'll turn it over to Jonah.

Jonah Frohlich – HIT at California HHS Agency – Department Secretary
Hello. Welcome to the call. I'm still catching up. I've just made a recent change in employment, and so I'm actually going to turn it over to Mickey. I think what we're going to do today is we're going to quickly review the recommendations that were made to the HIT Policy Committee that were made last month and then review the work plan and the framework moving forward, essentially the next month … of activities. Much of that's going to focus on the individual level provider directories and some of the basic elements that we believe are going to be important for those directories. I think today we're going to hear from two states. I think they're going to be joining us at about 11:00 eastern time, in about an hour, and then we'll discuss next steps.

I think that's the agenda for today. Mickey, have I left anything out?

Mickey Tripathi – Massachusetts eHealth Collaborative – President & CEO
No, no, I think that's right, Jonah, generally. Very good for not having stuff right in front of you. I know you're on the train, so I'm happy to walk us through this.

Good morning, everyone. Happy New Year. I'm Mickey Tripathi. I'm the chair of the Information Exchange Workgroup. Today I think that we have—for those of you that are logged on—the presentation up on the WebEx. Jonah, you just heard from. Walter Suarez is unfortunately unable to join us this morning. He's the other co-chair of the taskforce.

If you could flip ahead—I don't think I have control of this, if I'm not mistaken. Today, as Jonah said, we want to review just very briefly the Policy Committee meeting results and then talk about the work plan and the framework for the work going forward, which is about focusing now on the individual level provider directories. We're going to hear from a couple of states to start to dig down into a couple of real examples of states and organizations that are trying to move forward with respect to individual level provider directories. Really as a window into the issues that are starting to arise that I think will help inform the taskforce and the workgroup about what issues we think that we need to confront in the way of addressing barriers to be able to get greater instantiations of individual level provider directories aligned

with entity level provider directories in the market. Then we'll wrap up with some next steps and the target meetings going forward.

At the HIT Policy Committee meeting in December, we presented our recommendations regarding the entity level provider directories, and those were all accepted by the Policy Committee. It was a very good conversation. There are a couple members from the Policy Committee on this call, so I'll pause for a second and ask for anything they might want to add, but in general, I think it was a very good conversation around a number of different issues related to the recommendations. Overall, there seemed to be strong support for the recommendations themselves.

The one takeaway piece of homework that Dr. Blumenthal left us with was related to a little note that was on the bottom of one of the slides that had a piece of our recommendations related to alignment with CMS activities. So he specifically asked that the workgroup spend a little time thinking about the alignment of the entity level provider directory recommendations that we made and what CMS either has already with respect to directory-type of activities as well as what they are planning with the NLR and other activities. Come back and give a little more thought to how we might think about lining those up, perhaps using some of what CMS already has as a foundation for entity level provider directories with some of the features and characteristics that we were recommending and that the Policy Committee approved.

Let me pause here. I know Paul Egerman and perhaps some others on the phone who are Policy Committee members or who were there and ask if you have anything else to add.

Paul Egerman – Software Entrepreneur
The comment I would make is I thought you, Mickey, did a great job explaining a very complicated issue. It was an impressive presentation and there is full support for this direction. Dr. Blumenthal's comment about CMS is important, although my impression of how CMS operates is that it operates really by paying individual physicians, individual clinicians. So I also view his comment as being important for us to think through as we think of individual provider directories. Just say great job, Mickey.

Mickey Tripathi – Massachusetts eHealth Collaborative – President & CEO
Great. Well, thank you, Paul. I think as all of us have discovered this issue, the issue of directories in general is more complicated than I think any of us anticipated going in. I really appreciate everyone's help in pushing this forward and getting us to a set of recommendations that I think we as a workgroup are all happy with and the Policy Committee seemed to be pretty happy with as well.

I think it's a great point that you raised about the CMS connection to the individual level. One of the things that we may want to do, at the next meeting perhaps, is set aside a little time to talk about the overlaps with CMS. I might just direct the workgroup members to the new Physician Compare Web site that was just launched I think yesterday, which is sort of the analog, the CMS analog, to the Hospital Compare Web site, which of course has been up and running for a couple of years now I think. The interesting thing on the Physician Compare Web site is there is a level of information there about individual physicians and their practice affiliations, street addresses, phone numbers, things like that that are obviously very much aligned with some of the core content that we had recommended be in a nationwide entity level provider directory. It certainly begs the question of whether that can be a foundation upon which to build because it already does exist in a certain significant way.

Paul Egerman – Software Entrepreneur
It's just my observation—people can correct me if I'm wrong, but—CMS is different than other payers, other insurance organizations in that CMS does pay and track things on an individual physician or clinician level, whereas most commercial insurance payers seem to be paying on an organizational level. It's just a different structure, but perhaps because that structure, some of what CMS has done on a … level is useful for us to be considering.

Mickey Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

Jonah Frolich – HIT at California Agency – Deputy Secretary
I think maybe in light of the request from Dr. Blumenthal and Paul's comment, it would benefit this workgroup to hear from CMS and perhaps the program team that's developing the … so that we understand whether and how they're collecting and maintaining individual level and enterprise level directory database, and maybe from a health plan. We heard from a couple in the last hearing, but if we get a better sense as to how they're maintaining that information, it might help inform us.

Mickey Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Thanks, Mickey, for pointing that out. We need to do some homework at the ONC level about who is working on the Physician Compare. There is a … set of issues around the accuracy of the NPI data. One question that would be really interesting is whether the Physician Compare effort has added on any kind of validation or any sort of effort to improve the data quality of the underlying data. I think the … piece and the Physician Compare are distinct, but we would do well to connect with both of them. There is, of course, an issue that not every physician participates in Medicare, although certainly the vast majority do.

Mickey Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. I think one of the things we've heard over and over again is there is no one-and-done solution. But I think the thought was that that might be a foundation that gets us closer to where we want to be than anything else out there right now with all the caveats about how it doesn't have everything and it may not be perfectly aligned with what we were recommending.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
We're happy on the ONC end to both do some sleuthing on this new effort and who's in charge and what data they're using. Also, I know we tried before to get an NLR person on unsuccessfully, but let's give that another shot for our next call.

Mickey Tripathi – Massachusetts eHealth Collaborative – President & CEO
That'd be great. Thank you. The next steps, as by way of process, is we're finalizing a transmission letter of the recommendations to be formally conveyed to the national coordinator from the Policy Committee. Then also to work on a process to get the recommendations over to the Standards Committee and work with them in whatever formalized and/or informal ways to help push forward their work on the ELPD recommendations. To make sure that we're having the policy level iteration that we want to have as they move forward with the standards development.

The other piece of this that occurs to me—and Claudia, perhaps I could ask you, just put you on the spot for a second, I'm not sure that you know the answer. As part of the SNI framework, I think one of the—I forget what they're calling them, modules or I forget what they're calling the individual work streams that they have, but—I think the provider directory, there was a work stream related to that. I think that the SNI framework comment period is over, but I just wanted your sense of what that is and whether we ought to be thinking about reaching out to that team as well as they begin their work.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Yes. I actually talked with Doug about this yesterday, so I think there are a couple ways in which we might want to interact. One is simply to invite Doug or Arien, who's also very involved in that, to maybe present at our next meeting and get our input about what the focus should be. So that's one. Second, I think they are actively looking for participants in each of the work streams, so there might be an opportunity for individuals or organizations to be part of that process.

It's interesting, though. I think this points out some clarity we'll need to reach. The SNI framework is an opportunity to do additional work on standards. We also have reached out. I think our letter would be related to the Standards Committee around what we need, so we might need to do some ONC level work

around—maybe the message to the Standards Committee should be that the SNI framework work happens first and that our recommendations can inform that. I think there are some interesting sequencing issues that we might need to think about related to the SNI framework work and the Standards Committee work.

Let me reach back to Doug and see if maybe he could just join our next call and talk about that stream of work and what the timeline's going to be and what issues they'll be considering. I'll be sure that we can brief Doug and other folks at ONC on those recommendations, because I think it's high time that we did that as well.

Mickey Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Okay. Great. Thank you. Next slide, please. So just to begin the framing of the individual level provider directory conversation, and this is sort of harkening back to I think September when we had first thought about staging our recommendations into two pieces. One was starting with the national level and entity level provider directory and then turning our attention to the ILPD, which is where we are now. Going back to that and looking at what we had said then about assumptions, the first was obviously that the scope of the ILPD's should be sub-national. That leaves open the question of multi-state regions within states, what have you, but the idea is that the individual level granularity was something that seemed to be more appropriate at a sub-national level than at the national level, at least as we thought about it then. That was one of the assumptions that we had.

The second was about this question of what we're calling rigid conformance, where I think that at that time the conversation was such that we were anticipating that there would be a lot of variations perhaps at the state level. But whatever the appropriate level of consideration here is for scope of the ILPD that there could be variation in terms of what people wanted to use the directories for and therefore, what content might be maintained in them. I think that as we talk through the ELPD conversation, one of the things that we seem to have come to was that the idea would be that the ILPD's would sort of—and I'll put this in quotes—"roll up" to the ELPD's or have that be kind of the one overlap area of conformance. So that individual level provider directories ought to be able to map to entities that are on the entity level provider directory. With that said, I think that there's still a question of what do we want to say about conformance along other parameters that extend beyond what is in the entity level provider directories and what would allow that kind of mapping.

Certainly, one issue I think that has sort of raised the urgency of this is that states are currently implementing individual level provider directories and thinking through their strategies both for design and architecture as well as for the actual implementation. There is a need to produce some type of recommendations rapidly. One thought here as we think about these questions of wanting to have localized variation that maps to the ELPD's but allows the developers of ILPD's and those responsible for creating and developing them to have the flexibility that they need to accommodate their local environmental needs. Is that perhaps an approach for us is to focus on best practices to flag the issues that seem to be arising. What might we think of as best practices or recommendations for those who are embarking on ILPD's, and then have that be the form of the recommendations going forward. Then to essentially go about our work by using the framework that we use for the ELPD's. But at the end of the day having that set of recommendations be more in the way of largely best practices with perhaps some recommendations about conformance to alignment with the ELPD's, which might be one area that we make formalized recommendations on with some policy hooks from the federal authority. Then leave the rest of it to be in the way of best practices that will hopefully provide guidance but have less statutory and regulatory teeth than we might otherwise recommend.

Let me pause there and see if people have thoughts. Certainly Jonah, if you have other framing principles, we'd love to hear those as well.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Hello. I wanted to understand this first bullet a little bit more, about this sub-national level and what that assumption means. Since there's been so much discussion about PECOS and NLR, does that mean that it needs to happen at a sub-national level? I'm not exactly sure what that means.

Mickey Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, I think it's a fair question, Art. It may be one that we want to come back to, frankly. As I said, this is really just harkening back to when we were first thinking about this and had separated conceptually the idea of an entity level provider directory. I think there was a very strong sense that that ought to be national in scope versus the individual level provider directories. At the time, I think there was a strong sense that because of the local variation and because different states or state level HIA fund grantees were embarking on their own projects that those would sort of either because it made sense conceptually or just as a practical matter would end up being sub-national because of what was happening in the ground. I don't know if … has thoughts on that, but I think you raised a good point, that if we're talking about PECOS, NLR, what have you, it may be that it brings up the question again.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I think, too, in the spirit of minimal necessary to make progress so there's a strong feeling that on the ELPD front, especially as it aligns with, let's say, the way direct with conceptualizing the certificates and stuff, that there was just a low-hanging fruit and a requirement that could block progress. That progress in terms of individual level providers wouldn't be as uniform, that there was a lot of investment being made through the HIE program, it wasn't being made in every single state and the way the uses were variable from state-to-state. I think one thing we should just be aware of is whether they are (a) assets, and I think the NLR and PECOS bring this up, and (b) whether there's a likelihood of a national investment separate from what the dollars that have already been invested through the HIE program or other things in terms of thinking about the most realistic path and the way in which to make the most rapid progress.

My initial feeling is it probably is that the state level efforts are really where the gain is right now. We certainly need to learn more about the federal data source options. They could either be seen as a basis for something national or as a data source that states could use. I think either could be a viable option. I just think we need to be a little careful at not teeing up a grand thing that's unlikely to be implemented.

Paul Egerman – Software Entrepreneur
One of the assumptions I'm getting from listening to what you just said, Claudia, and reading the slide here is that the real focus of the ILPD is the HIE organization as opposed to when we were doing the enterprise directories, where the focus was really sort of like the EHR systems. Also implicit in that it looks like basically routing systems as it relates to synchronization among EHR systems. This is more of a focus on—tell me if I have this right—HIE organizations and probably, I'm speculating, query response kinds of interactions as opposed to EHR synchronization interactions.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I'm not sure I would make the assumption of query. For instance, I think one of the things Arien talked about a lot was certainly we can assume a world like e-mail where folks know each other, but there might be circumstances like utilization of that, like in the ER or discharge, where you may want to look up the individual provider and get it to them. I think both are quite conceivable. I don't know that I would necessarily put this in a query response. I think that's possible, but I think there could be other, more directive messaging that could certainly use individual level information.

Paul Egerman – Software Entrepreneur
Is the other part of what I got as an assumption correct, the real focus is the HIE organization for the individual provider directory as opposed to the ERH?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
You know, maybe these worlds are starting to merge in my head, but for instance, I'm just thinking of a scenario where I am a provider, I have the direct specs built into my EHR and I'm wanting to get a piece of information to another individual document. I can imagine our grant supporting how that would happen, but it's possible it's not being routed through in HIE. These kinds of things start to merge in my head, where I don't know if you're considering that an EHR or HIE or what, but the scenario might be that I'm sending it directly from my EHR to their EHR, I'm using the provider directory to support that.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
One of the things that we've heard in our planning process in California was an interest from providers to be able to look up where an individual physician practice is. Because they may know that a patient belongs to a physician but they may not know where the physically they work and they have to forward a summary of documents to that physician HR. They described the need to have the ability to look up that individual physician. They know who the physician is; they don't know who the practice is. It could be a function that is also integrated somehow in EHR. It could be something that's a value-add that's provided by an HIE that's outside of the ERH. I think that might be a good question for us to look for, but it was certainly something that was articulated during our planning processes as a valuable tool that we could use to help providers and hospitals … summary to each other.

Paul Egerman – Software Entrepreneur
That's helpful, Jonah. Again, I'm trying to understand the assumptions and framing. It seems like you've got conventions like best practices as opposed to when we talked about the EHR system we always seem to talk about standards and certification and meaningful use. The way I'm understanding it in determining these best practices is that this is functionality that the HIE's would offer and that could be very useful for people operating within an EHR environment. It's really not part of the EHR system; it's a resource to the EHR users.

Dave Goetz – State of Tennessee – Commissioner, Finance Department & Administration
Would it be helpful if we sketched out what we think are the five most common use cases on an ILPD? I mean, just listening to you, Jonah, it seems very clear to me that what you're describing would tie back in through an ELPD because that's what you're wanting to basically accomplish, that level of exchange but you just don't know where the doctor is or how to tie into whatever entity structure that he has, right? Does that make sense? It's been kind of a process map, is what I'm thinking.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Yes, Dave, you're actually anticipating what I think is on the slide three slides from where we are right now.

Dave Goetz – State of Tennessee – Commissioner, Finance Department & Administration
Sorry.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Don't be sorry. It specifically asks the question "Would a chart of use cases like what was put together for ELPD's be useful?" It sounds like you're suggesting the answer to that would be yes.

Dave Goetz – State of Tennessee – Commissioner, Finance Department & Administration
I think so.

M
I would agree with that.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I think there's something about this sub-national level that when we had these discussions back in … there was talk about how do you know who someone is. Is the directory trying to assure to the person looking for a name or an individual that that person has been vetted and their identity is confirmed, that we can begin to think along the lines of authentication or authorization? Is that one of the functions that we want the ILPD to serve?

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
I think it's a great question and I think it's an open question about what are the rules about being listed? What are the rules for being listed on the ILPD, which is I think what you're getting at, and would that be something? We did have this conversation a little bit with the ELPD's and also in thinking through the overlaps with the authentication considerations that the Privacy & Security Tiger Team were having as

well. I think the question, if I'm understanding it, Art, is kind of a question of is the process for being listed on the ILPD one that is addressing the question of validation of the individual and authentication in whatever level of authentication you want to think about there with identity grouping and all that? Or is the fact that they have been authenticated in some other way something that is represented in the ILPD but is not part of their necessarily being listed in the ILPD? So their credentials is a part of that and open the possibility that you could be listed, but if you don't have a credential then you don't have a credential and that would severely limit what kinds of transactions you could partake in.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Mickey, when you say "credential," are you talking about digital credential as opposed to medical credential?

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Right. Yes. Absolutely. It does open up whether you might want other types of credentials being a part of that. Again, the consideration of is there some type of process for validating those credentials that would be a requirement, sort of a … requirement or … requirement? Dave Goetz I think corrected me on my grammar on that one. … requirement for being listed? The value, therefore, of that would be that others, to the extent that there was trust in that process, could then use that for other purposes and could piggyback on that versus, again, it just being a place where those types of credentials are listed and the sourcing from other places that have some presumption of trust related to it.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Mickey, for this discussion if I could make a suggestion, a terminology suggestion, that when we're talking about authentication that we talk about digit certifications and when we're talking about medical credentials we call it medical credentials. Otherwise, I'm afraid over the phone—I just got a little bit confused when you were talking, so I would encourage digital certificates and medical credentials to help us keep clear which we're referring to.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Right.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I'm thinking, just through this conversation, there are sort of three layers you might think about. One would be does the person have a medical license? For instance, with … which is leveraging the medical society and the licensing information, that would be one way of saying we got our data from the medical society, they're the source for that.

Another would be is the actual information about address and practice location accurate? We see with … there's a distributed way to have a doctor correct their information about phone, fax, how you can reach them. Then a third issue is actually, they've been authenticated for electronic exchange of information, and that could be a third issue. You can imagine either building a system that builds in a way to address all of … everyone that … corrected. I love, Mickey, your point, which is you could actually build in just a checkmark saying this person has a valid license, has … their information and is authenticated, almost say that users can determine at what level they need to be able to exchange information. I think there are some very distinct layers that speak to very different functions.

Jim Golden – Minnesota Department of Health
One of the things that I'd be very interested in making sure that we explore is the relationship between the ELPD and the ILPD. I know we sent it off to probably the Standards Committee to be fleshed out, but one of the things that I like about the ELPD is that once the entity takes some responsibility for making sure that they are listed, is there any way to leverage what they would naturally be doing as part of their business activity inside providers coming and going? Maybe more direct routing with … so we can leverage what they already need to do to maintain their individual level providers within an entity so that might somehow … we're doing with whatever directory we have?

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO

Right. I guess if we said, to the first part of your point, that we want to think about how those linkages are made so if we want to say or assert that in thinking about a best practice or actually a policy hook that says that if you are using state level HIE funds to create an ILPD. One of the things that we would want to strongly recommend, encourage, require is that every individual listed in the ILPD maps to an entity on the ELPD. Maybe we can discuss what that actually means and whether I have that right, if there's any agreement on that. The second I think is it seems to me, if I understood it correctly, more about a consideration of the business processes and whether it would be in the interest of all those entities to be essentially populating the ILPD with their individuals. That's hopefully something that they see as being in their business interest.

Peter DeVault – Epic Systems – Project Manager
A couple of comments about what you just said. First, in terms of mapping or pointing from the ILPD to the ELPD, we should also be clear that it could be a one-to-many situation. One physician could be involved with several different entities, more than one, more than two. It's hard to know how many.

The other, though, is I'm not sure—although this is perhaps too much detail—that we necessarily have to require that every ILPD, every individual, be mapped to an enterprise, to ELPD. You might run into some difficulties with that. When we get into the issue of any in governance, one of the vehicles that any in governance could possibly utilize would be that there's a bad behavior on the partisan players is to remove that organization from the ELPD. So if that were to occur you would have some individual clinicians that would not point into an ELPD because their directory was revoked. I'm speculating in saying that, but it's just an observation. It may be possible that there are individuals that really legitimately don't point to any entity.

Along those lines, we might not have only one-to-many or one-to-none, but we might actually have ILPD entries pointing to more than one ELPD. That is, the scope of coverage of an individual ILPD might not be the same as the scope of coverage of the ELPD and there might be several ILPD's in a state, for example, and one ELPD or vice versa.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Right.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Just to … I'm hearing strong interest to have us lay out use cases like we did before. It did seem like that was very clarifying on the ELPD. An interest in thinking through the mapping of ILPD and ELPD but with the caveat that there's a nuance there that's important and perhaps we'll end up in a strong recommendation context rather than a rigid conformance that this must be done.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
That sounds right to me.

Tim Andrews
I would say, to Paul's point, that it is a governance issue. So ultimately you have to tie up to governance, but if an ELPD gets kicked out, which was his example, then actually, I think that would be a legitimate reason to at least take some action on the ILPD front as well because those people have no connection point at that point in time. The question is what do you do about it? You need to deal with that issue at some level. It's not clear what you do there, but it's a governance matter. It's not clear to me you have to say it's okay to have no connection.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Right. There's a ton of complexity there. I think I understand what you're saying, Tim. Certainly, in a way it kind of depends on the connection between the individual and the entity, I would think. If you were a part of a practice, a large group practice, and that is the entity and you're an employee of that practice, if the entity is delisted I would think that all the individuals are delisted because they are employees of a practice. If you were being mapped to multiple ELPD's because you practice in those multiple locations, it may just be that you're not an employee at those places but you have certain privileges or certain rights

there that you can no longer exercise through that particular entity. You still have legitimate mapping, like your own practice.

Tim Andrews
Exactly. The issue is that if you think about it from a security perspective, if an entity is delisted, you have to assume you really don't want to send messages to people through that entity.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Right.

Tim Andrews
If you look somebody up through that entity and they're still in the ILPD, do you even want to enable that? Because people may attempt to send them messages, just because they've been "delisted," you have to make sure all the T's are crossed and I's are dotted to make sure you don't end up sending messages to people that you really shouldn't be.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Or through pathways—

Tim Andrews
Through pathways, right. Through inappropriate pathways, right.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Okay. Claudia, back to your summary, I think that makes a lot of sense in terms of what seems to be the center of the conversation here.

Tim Andrews
Mickey, I'm assuming—in Claudia's summary she talked about licensing. Licensing is its own set of complexities, especially because different states license different things. I assume going forward there will be an opportunity to discuss that.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Yes. I think that actually moves us to the next slide. I'm sorry—I'm looking at my own local version. Let me get back on the WebEx. The next slide is the framework that many of you may recall from the ELPD's. One question for us here, one proposal that I think we would have for the work group is that we basically use the same framework but go through it in the same steps. I think, Paul, that would be where we would have the opportunity then to dig down into each of these dimensions and start to ask these specific questions. Does it make sense at a high level to say let's use the same frame work; it'll get us the same place? It may be that on the right hand slide, the recommendations are more about best practice recommendations rather than actually being policy actions per se, but I think that's something that we will come to a determination of once we have a better understanding of the use cases and what the details are.

Jonah Frolich – HIT at California HHS Agency – Department Secretary
I think this makes sense to me. As you said, the recommendations are less likely to be policy focused but more operational for the state HIE's and potentially for the electronic … who may be implementing or considering some of these recommendations. The only thing of concern on the policy side is whether or not there might be some … meaningful use considerations for this, but I don't think we know that yet.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I think the other thing—and this came out at our grantee meeting in the great panel discussion and we'll hear from some of those folks today—is the potential uses for an individual level provider directory that spans well beyond meaningful use. That might include quality reporting. That might include insurance exchanges. While I don't think that's explicitly a policy question, I think in our conversation it would be great to hear from state level folks who are implementing to talk about the uses they think are the most

likely and how to implement this in a way that doesn't eliminate the possibility of using the directories in expendable ways over time.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Right. I think one of the things I've been struck by—as we think about this question of is it policy or best practice at the end of the day, and it certainly might be a mix with the majority being best practice with a couple of specific policy recommendations or something like that—is that in just being out in the market and working with a lot of organizations both at the hospital level. In practices, I've been struck by how many actually, as they think about health information exchange, have been using the Privacy & Security Tiger Team recommendations as a guidepost in what they do. Even though those don't have the force of law and they really are just recommendations around best practices, at least from what I've seen—I'd love to hear other's perspective on this—they do provide some level of guidance I think for a lot of organizations and seem to have a lot of traction, seem to be very helpful, at least from what I've seen in the market. Hopefully these kinds of recommendations, even though they are in the way of best practices, would offer some of that same benefit.

Unless there are other thoughts on these recommendations we can move to the proposed work plan which is on the next slide. The schedule is we have the taskforce meeting today. On the 13th we have a full workgroup meeting where we want to certainly tee up what we've been discussing with respect to the ILPD's and where we are in our approach there to get the broader workgroup feedback. I think we'll want to talk a little bit about the CMS question and how we address that. We also want to reserve some time to discuss the PCAST report as well.

As many of you may know, there is going to be an announcement soon I think about the launching of a separate PCAST working group that's going to be focused specifically on addressing the recommendations that came out of the PCAST report. I did send to the full work group before the holidays the report itself, or a link to the report, and to the ONC Web site that is requesting comments that I think is open until January 17th. One of the things that we'll do is send out a reminder to the workgroup members that we'd like to have reserve some time for discussion of the PCAST report. Then perhaps either formalize any thoughts that we might have that could either be inputs onto the Web site and/or could be formally presented to that PCAST workgroup once it's up and running as well. That's for the 13th.

Let me pause here and see if there are any—since we have a large number of members of the workgroup on this task force—thoughts there. Also, Claudia, if you had any other thoughts on that, I wanted to just pause here for a second.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I know, just also encourage individuals to respond to the RFI. They're a set of questions that we can consider … listed there. This also raises an interesting governance issue for the Policy Committee because while I'm not sure that we'd be handing over recommendations per se, it would be great to have some kind of way to relay our input to them. Maybe the best way to do that is to invite the chairs of the PCAST, that work group that's being formed, to our discussion. Or maybe there's some kind of document we should relay to them. We should think about how to be sure that whatever discussion we have gets transferred somehow into their process.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Right. Yes, that makes sense.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
One thing is whether it would be helpful to have a presentation on the report as part of that meeting just to help parse it. Think about whether—there's been some blogging and certainly some interaction about it—that would be helpful. We can either get somebody from the White House and the committee or somebody from the ONC team to do that.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO

Right. I think that would be really helpful. I don't know what other people think. Well, there are no votes against and one vote for.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Mickey, you win. You know, it was in our report, so we've certainly been involved in that, but let me just look into what the best way would be to have a little bit of a briefing on that.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Okay.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Certainly, it was materials from the brief that David spoke at and others from the White House.

Jonah Frohlich – HIT at California HHS Agency – Department Secretary
I think it'd be helpful. Did you mention that there are some members of this task force that are on that force who are expecting to be on that workgroup?

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
I don't think the workgroup has been formally announced yet, so I don't think we know officially who's on it.

Jonah Frohlich – HIT at California HHS Agency – Department Secretary
Okay. Is there any interest to have some kind of crossover so there's some membership?

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
I would think that would be very helpful. Again, I actually don't know what the process is for even forming that group.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
It's an ONC process involving several folks from our policy group. I've certainly been representing that point of view, but I'm not the only person who's participating.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Right.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
So yes, you're right, Mickey, it hasn't been announced yet. I don't think the invitations have been sent out yet.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Right.

Jonah Frohlich – HIT at California HHS Agency – Department Secretary
Maybe Claudia—I'm not trying to volunteer for anything here—if there are some considerations about having some cross-pollenization with this group and probably others—… security especially—I'm on that committee. I think it's been very helpful to have people like Paul, who's been on both, and others in this work be able to help inform us to what's happening in other committees and to inform them of what we're doing. If there's any opportunity, then I would suggest we try … elect that committee with representation from this and others.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Yes.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
So just on the work plan itself, really, we can just think about the end game here, which is that we're targeting being able to prevent recommendations on the individual of the prior directories for February 2nd,

the Policy Committee meeting then. Just working our way backwards here, we want to be able to roughly at the end of January—January 28th I think we have a workgroup meeting scheduled—to have that be the meeting where we have formalized our recommendations and get the approval of the workgroup on that. So between now and then we have the workgroup meeting and then two taskforce meetings to work our way through the issues, tee up what we think are the salient issues, get some consensus around them, and then be able to formalize those for the 28th to get that final approval and then presentation to the Policy Committee.

Paul Egerman – Software Entrepreneur
My observation is this is an aggressive schedule.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
In our experience to date, yes.

Paul Egerman – Software Entrepreneur
Just thinking about what Claudia said before about the enterprise directory and the EPLD, she said it's low-hanging fruit. As I've listened to this discussion, I'm starting to realize she's right. The individual ILPD side is far more complicated. It's a fascinating issue. We'll do very good if we meet this schedule.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Yes. Well, I guess there's a monthly meeting. So is there a Policy Committee for the beginning of March already on the books?

Paul Egerman – Software Entrepreneur
I'm sure there is. I wasn't suggesting altering the schedule.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Right.

Paul Egerman – Software Entrepreneur
I was just making an observation. We're going to have to work hard to do this. We should go ahead and do this. I'm not trying to dissuade you from that.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Okay. Since one of our co-chairs isn't on the phone we can absolutely commit to this, right, Jonah? Are there any other thoughts? Jonah, do you have any other comments to make on the work plan itself?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
No. I agree to the schedule. We'll do what we can to meet it. We're going to talk with two of the states in the next hour, is that right?

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Yes, they're coming on at 11:00, so just in about five minutes.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Okay. I really like the idea of us getting together … as we have here, the use cases.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Yes.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I think that was really helpful and helped us get through some challenging moments when we were discussing the enterprise level directory. Maybe we can take that on at the task to put some … models together to bounce off the committee. Do you think we could do that for the next workgroup meeting?

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO

Yes, I think it would be very useful to have that for the next workgroup meeting. Perhaps we can loop back around with Walter, who was the one who did the … ones for the ELPD. I agree with you: it was a significant breakthrough in our conversation.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes. … think we can probably volunteer for that. I'm remembering our previous … we started the discussion. I think it took us a little bit longer, but now we have a process that I think will work well for the ILPD. I agree with Paul. It's even more complex than the ELPD discussion, with probably some less strong policy hooks or policy leaders that we can deploy. I think it'll make for a very interesting and a very important discussion.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Okay, great. The next slide, actually I think we already got to the basic point of that, which is to say that we want to focus on use cases. I think that maybe we ought to leave it at that, to say that that will be the significant piece of homework for the next workgroup. I'll try to do that so we can circulate them enough in advance that people will be able to have a little time to think about it, which I think we should be able to do because we have a workgroup meeting and then we move to the taskforce meeting after that.

Are our guests from the two states who have agreed to speak today on the phone?

Rick Rubin – OneHealthPort – CEO
Yes. This is Rick Rubin and Sue Merk with OneHealthPort.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Hello. Great. Welcome.

Sue Merk – OneHealthPort – Senior Vice President
Good morning.

Rick Rubin – OneHealthPort – CEO
Good morning.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Good morning. I'm not sure—Judy or Kory, did we have an order in which we're going to have them speak?

Judy Sparrow – Office of the National Coordinator – Executive Director
I just put down Rick and Sue would go first, and then Linda second.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Okay, great. It sounds like Rick and Sue are here. I just want to welcome you and thank you for agreeing to speak to us. Really, what we're hoping to get as a workgroup is really just your on-the-ground experience, so what you're trying to accomplish but also what are the obstacles that you're confronting and how do you think the workgroup could be helpful in helping you move forward? I think we have roughly ten minutes each, is that right, Judy? I'm just looking at the clock here. Probably ten minutes each.

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Okay. Great. Can I turn it over to you, Rick and Sue?

Rick Rubin – OneHealthPort – CEO
My name is Rick Rubin. I'm the CEO of OneHealthPort. With me is Sue Merk. She is the Senior Vice President for Operation …. We have a pretty brief timeslot this morning. What Kory asked us to do is I'll

start off and just give you a sense of what we've been doing at a high level and then Sue will spend a little time talking about a little more detail about some of the questions you posed. Then we'll be happy to take questions from the panel.

I think we distributed in advance a slide that just sort of shows a picture of the different work we've done in this area. I'm not going to talk in great detail about any of these. About eight years ago, we started off with a security service. This is not a directory service per se, though it ends up indirectly serving in that capacity. It's really based on identity management and authentication, a way to have common single sign-on across the community. In terms specifically of this issue relative to provider directories, it has also served as the front door to future directories, so that was very important, the way that people get into those other directories and the way that we know they are who they say they are as they manage their information within those directories.

A few years after that, in response to some issues with the NPI and the way that was rolling out across the country, we were asked to put together a very quick and dirty directory of NPI numbers, sort of a crosswalk for people. We thought that would be a three-month throwaway project. I think we just turned it off, what, a few months ago? There was a lot of hunger for that type of information in this community.

The major effort we're embarked on—in 2010 the provider directory services—this is mandated by a piece of legislation focused on administrative simplification. The business driver here is a common electronic method for collecting information from providers to support credentialing and privileging in hospitals. So that effort went live last year. Sue has led that effort and will provide as much or little detail as you'd like about that. I think the key point there is the business driver was to solve a credentialing and privileging problem, sort of the annoyance providers field filling out the same information over and over. However, when you look at this chart and you think about all the different applications and organizations that are looking for cleaner provider data, there's an enormous opportunity to use that same provider data service to solve a number of problems in the community.

Finally, in 2011 we'll be rolling out a statewide HIE. The vendor we've chosen is Axway. That provider directory will initially be focused strictly on individuals and organizations that are subscribing to the HIE. They have actually bundled Salesforce.com into their application. One of our key business requirements was that there be a self-registration … because that is certainly something that we've learned over the years in these different directory services. It has to be very easy for the individuals and organizations involved to enter their information and maintain their information. As you can see from this picture, while the NPI directory will be going away, the provider data service piece, the security service and the HIE will be integrated and worked together. Again, we can talk as little or as much about that as you want.

I think the only other two quick comments I would make is that certainly, what we've experienced here are the business drivers behind directory services have not been being able to locate your HIE or HIP trading partners. They have been by and large other business drivers that have been more prominent and that have provided the business case, the revenue, the resources, the interest to move forward. Then being able to repurpose those for HIE is sort of a side benefit. The second overarching comment I would make is that there is far more interest in our market in solving local directory problems that in investing significant resources to be able to understand, for example, how to contact a doctor in Boston. That's not to say there's no interest in doing that, but that would be pretty far down on the list of priorities here.

With that, I will turn it over to Sue and ask her to make a few quick comments. As I said, we'll be happy to respond to questions.

Sue Merk – OneHealthPort – Senior Vice President

Yes, this is Sue Merk. I think the area that I focus on is really trying to meet the business needs of the healthcare community in Washington State, where over the years we have had a number of discussions about a central provider database to actually support a number of different projects. Rick mentioned a number of those that historically we've worked on the NPI. We learned a lot about how people think of their data and how they maintain it in that project and decided with the next one we wanted an approach that would allow us to use a database that supports directories and other things as well. Our design has

been around a provider database as the core master database, but subservient to that are going to be directories and other databases for specific uses. I think that we can meet national needs as soon as those are identified by looking at is that a child of the master database, what additional data elements do we need to connect, collect and maintain, and what's the best way to do that? For a large organization, that's usually not maintaining data manually but to supply either LDAP or other file directories to populate their data.

So we've looked at a variety of those things. We see and get requests from folks at the state wanting to do workforce analytics. There are all kinds of uses of provider data once you have it. Anybody who's worked in the health plan world—I was the CIO at a health plan and we had 27 different databases supporting provider information. We finally created a master database to make use of that data to various departments so that we could get it under control and maintain it in one place. So our approach is to start with that database and see what are all the business needs and various uses of that data. Hopefully, as more as developed by your group and others nationally, we'll be able to meet those same needs with an approach of looking at either a view or a directory that gets … on that master data.

With that, I'll stop and ask what kinds of questions you have.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Thank you so much. Any questions from the workgroup? I have one. Sue, I think maybe you were alluding to it—maybe I was confused or maybe I confused myself in listening—is whether this question of— I'm not sure when you joined our conversation. But one of the things we're going to be grappling with is recommendations we might make about they connection between individual ILPD's that get rolled out at the sub-national level and the connection to nationwide ELPD, which was a recommendation that we made and that got approved by the Policy Committee. I just wanted to get your thoughts no that, whether that would be something that you would find helpful at the end of the day. I did see on your think not wanting mandates but wanting more granularity and more robustness of standards. I'm not sure whether that, in your mind, would be in the category of a mandate or in the category of helping with the … of standards.

Sue Merk – OneHealthPort – Senior Vice President
I guess my first choice would be that there's a standard that says these are all the essential data elements that you should exchange and here are the ones that are optional, because everybody's going to be in a different place than where their data is and how they collect it. My second thought would be I prefer the query response method than the database synchronization, mainly because I'm not that interested in maintaining everybody else's data for an occasional query. My neighboring states—Idaho and Oregon, even Alaska—I may do a lot more work with, and it'd make sense for me to evaluate does it makes sense? There's frequent enough traffic that I should maintain their data in my database or should I simply have a really good query response to go check their database for the latest information. To me, the query response allows us each to maintain our data, keep it accurate, keep growing it and not spend so much time just wading through other people's data that we don't know the currency of.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
That's really interesting. I think it tees off of our ELDP discussion, which is the idea of networks or distributed data with interoperability across them. It also speaks to the same principle we have with individual providers, that whoever is closest to the data should maintain it. I think those are really important principles that we can take forward into the discussion.

Rick Rubin – OneHealthPort – CEO
One other observation about this individual and organizational piece, a good deal of the energy and effort on the security side of what we do is understanding and maintaining the multiple linkages and relationships between individuals and organizations. For better and for worse in healthcare, your access to information is much more often determined by who you work for than who you are. So that becomes a very key question and is different, for example, if you have a credentialing database or something else. The primary focus may be on the individual. So many organizations, so many individuals have multiple relationships.

There's a lot of turnover and transition, those relationships are changing. People grant privileges to other people outside their organization to have access to their information, to represent them in the electronic trading market. That is one of the single biggest challenges. Frankly, it's part of a value that gets added to help maintain that. If we're going to maintain that, it's absolutely critical that we have individuals with delegated responsibilities within each of those organizations. No central authority will ever be able to keep track of those kinds of changes without active and engaged administrators in a delegated role.

Sue Merk – OneHealthPort – Senior Vice President
Yes, I think that's a key point, too, and that is when you're asking someone to maintain their data, it's easier for them if they're doing that in one place and not 50 different places. So if we're going to ask the provider community, which can be a one doctor practice or a large multi-specialty clinic or a health system, to maintain that, they face challenges of their own just keeping their records current. Asking them to maintain it in an external database multiple times is a nightmare that they don't want to deal with either. We've tried to centralize so that they have one place to maintain that for multiple uses, and I think they really appreciate knowing that's the place they go that everyone else should look to as the most up to date information about them.

One other thought about the entity—I think from my years at a health plan and our experience here at OneHealthPort, it's clear that the entity relationship where an organization as an entity and the individual practitioner can have relationships with multiple entities. We've learned that however you structure the data, you better plan for a complex hierarchy, that that person can have one to many relationships, and they change. The one thing that is constant is the change of their relationships and the number of people related to any one entity. So we've tried to make that as flexible as possible. It is amazing, the iterations you can go through in an organization in a single year. Data is certainly not static when it comes to the relationship of the practitioner to its entity organization.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Right. Great. Well, thanks, Rick and Sue. I apologize, we're on very tight timelines here, but we really appreciate your perspective and your willingness on short notice to help us out here. Is our next speaker—?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, Linda's on.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Great. Hello, Linda. How are you?

Linda Syth – Wisconsin Medical Society – Chief Operations Officer
Hello.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Good. Let me turn it over to you then. Thank you.

Linda Syth – Wisconsin Medical Society – Chief Operations Officer
It was interesting to listen to Sue and Rick because it could be my presentation. We're not dissimilar in our thought process at all. We began what was originally a physician directory for business use for our members and physicians in general around improving the cost and quality data as people were looking for cost efficiency using claims data or clinical repositories and looking at data for quality improvement. Our physician data was really the best data anywhere. One of the reasons is because we have the one-to-many relationship. You start with just one provider, but we can keep track of many relationships, and a lot of databases weren't built that way.

So we have since changed the infrastructure of our provider database to one, allow us to have all HIPPA providers and then two, to make sure that it was nimble and flexible, scalable and interoperable. Where we've been in the physician provider directory for many, many years, we've really been in the last four

years in a broader provider directory effort. So we have, I think much like what Washington has, a full 900-field data set but are using pieces of that data for different purposes. I would echo what they said: our job is just to have this data, but then to help the practices in the business uses they need so they don't have to maintain multiple sources within the state of Wisconsin alone. The actual state government provided data is handled in probably nine different databases. Because of restrictions on funding, etc, they've not been able to keep their infrastructures up to date, so they can't just take one data set. Like a large practice will have to give their data nine different times to the state of Wisconsin. The changes, you don't keep up with all the changes that happen.

We have the same premise when we did our provider directory. When you ask me what key issues or challenges we're facing right now, because we've had a process for many years on physicians and our integrity level is over 98%, now looking as we add all HIPPA providers, how do we maintain that same integrity level? So we're going through the process to figure that out. For large integrated delivery, we can get their whole HIPPA provider data set. Luckily for us, the Wisconsin Rural Health Cooperative does all the credentialing for the critical access hospitals and physicians that participate so we can get a bulk of data that way that is also highly accurate. Then we're going to have to figure out the white space and what areas do we not have the most accurate data, and then do we go to the associations that might be for some of those groups? We'll be looking at how do we deal with quality and maintenance ongoing as we do with our own data.

As far as best practices, I echo what Sue said: you have to have something that's scalable, that you can add a data element but not destroy the integrity and other parts of your data set. It really needs to be configurable. Something I would emphasize is terminology and semantics. We're amazed. I've said this is numerous forums now, but specialties—there's just really no universal agreement on how specialties should be listed. So we went through a huge process to work on how we listed our specialties, but everybody should do it the same. You need to have the ability for an entity to give you the data in multiple ways. Whether it's a large practice or a large integrated delivery, would they be doing it in bulk? You have to have the delegated authority, you have to have an individual be able to do it, you have to have the tracking mechanisms to know what changes have been made, and have security so people feel safe and can trust the data going forward.

The next question at entity level provider directories, we actually have a call this afternoon on this topic of what are going to be the ties between our individual provider directory and the entity level provider directory? I think it goes back to the one-to-many. We have an ultimate parent ID address, although we can have many, but I think some of your discussion earlier, I think you're right: you can't just have one direct IP address. Also, provider directories, if you're using them for multiple purposes such as licensing, you have providers that maintain the license even though they may be retired. Make sure that any policy leverage you put in are more recommendations than requirements, because there are lots of little nuances that happen.

When I looked at your diagram, the one piece that I think I wouldn't forget is the risk management and liability that is often behind provider data and the uses. Ultimately, that's how people look at the data and why they require what they do. So I think that's local. Don't forget that as you're working.

The other thing is, I think to reduce administrative cost and also increase the sustainability for each state's FDE effort I think it's important to allow them to leverage what they have. I know Soren is on your group and in many states CAQH has a huge presence in their state, and that is a perfect source or resource to go in the individual provider level directory. Even though they have a business use around credentialing and that's their business, why would you not want to allow each state to utilize whatever resources they can?

When you announced, Mickey, at the beginning about the Physician Compare, I did go out and do a quick search on my mother's cardiologist and there were over 50 locations for him listed. That just shows you the complexity in Wisconsin and the complexity that we could help a CMS deal with.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO

Thank you, Linda. I actually have one quick question. You had said that this afternoon you're going to have a conversation about marrying the individual level data to an entity level directory. In talking about that, is that an entity level directory that's going to be launched by the statewide HIE?

Linda Syth – Wisconsin Medical Society – Chief Operations Officer
Yes.

W
One other thing—and I hope I'm remembering this right. Under the HIE grant program, I believe you guys are going to work together to include … as well as EHR type, is that right, in the … directory?

Linda Syth – Wisconsin Medical Society – Chief Operations Officer
That's correct.

W
So there's another layer of richness that's being added related to meaningful use and related to being able to have accurate … all the way to the …

Linda Syth – Wisconsin Medical Society – Chief Operations Officer
The other piece—because a lot of the directory functionality was built around quality and cost efficiency, we also have some other elements in our database to list NCQA certification when it comes to a medical home, diabetes guidelines, all sorts of different elements that are also available that will help, we think, in meaningful use in the future. So we're going to keep our eye on that.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Okay. Great. Well, thank you, Linda. We really appreciate it. I think we now need to turn to the public comments, is that correct, Judy?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes. We're ready for that. Operator, can you open the line and see if there are any comments from the public?

Operator
Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
Mickey, while we're waiting, the full workgroup meeting is January 13th, correct?

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
10:00 to 12:00 eastern time?

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Was that written wrong?

Judy Sparrow – Office of the National Coordinator – Executive Director
No, no—I'm just checking.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Yes.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Mickey, my sense is for that meeting, if we focus on a brief briefing on key tasks followed by discussion and then maybe just an update on our work plan for the individual level work, that's probably two hours.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Yes, I agree with that.

M
Although, Mickey, it would be helpful if we could start on use cases.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Right, but that's a larger work group, not the taskforce.

M
Sorry, I got confused.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
No, no. We could give them an update on what we're doing, but I think the use cases would be within this group.

M
Sorry, I got confused.

Judy Sparrow – Office of the National Coordinator – Executive Director
Operator, do we have any public comments?

Operator
We do not have any comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Well, thank you. Thank you, Mickey, and thank you, everyone.

Mickey Tripathi – Massachusetts eHealth Cooperative – President & CEO
Great. Thank you, everyone.

Public Comment Received During the Meeting

1. Great meeting and thank you all for your service in this important area.